

BadgerCare Reform Demonstration Waiver Amendment FAQs

The FAQs below provide information for members, providers, partners, stakeholders, and the public regarding the approved waiver. These FAQs were updated on October 31, 2018.

A. Background and General Questions

1. What is a section 1115 Medicaid demonstration waiver?

Section 1115 Medicaid demonstration waivers grant federal approval to allow states to test innovative approaches to improving health care that would not be possible under normal federal program rules. In Wisconsin, the Department of Health Services (DHS) has had authority to operate the BadgerCare Reform section 1115 waiver since January 1, 2014. This is referred to as the BadgerCare Reform demonstration waiver. Wisconsin is one of [40 states that use the section 1115 waiver process](#) to transform their Medicaid programs. Nearly half of these states have waivers or amendments currently pending with the federal Centers for Medicare & Medicaid Services (CMS) pursuing innovative and patient-centered approaches to health care reform.

2. What is the BadgerCare Reform demonstration waiver?

The approval of the original demonstration waiver in 2014 led to the historic expansion of coverage to tens of thousands of vulnerable Wisconsinites, and has made Wisconsin the only state in the nation to have no coverage gap without the Affordable Care Act expansion.

We have received approval for two parts of the BadgerCare Reform waiver. First, we were granted an extension to the existing waiver, which expires on December 31, 2018. This extension allows us to continue to provide Medicaid coverage for adults between the ages of 19 and 64 years old, without dependent children, with income at or below 100 percent of the federal poverty level. One change will be made in the extension of the existing waiver. Effective January 1, 2019, individuals who are in an extension period (known as Transitional Medical Assistance) will no longer be subject to premiums. DHS will be providing additional information to impacted individuals prior to this change.

Second, DHS received approval of an amendment that allows DHS to further these achievements. The amendment's focus is on initiatives intended to improve health outcomes and improve the cost-effectiveness of Medicaid services. The demonstration permits DHS to address some fundamental social determinants of health for our Medicaid members by encouraging and assisting members to pursue healthy behaviors as well as incentivizing childless adults without dependent children to gain job skills and employment. The amendment also allows us to expand coverage for residential treatment for substance use disorder to Medicaid members.

3. Who does the waiver affect?

Medicaid members affected by the demonstration waiver are largely limited to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including of the [federal poverty level](#). As of September 30, 2018, there were 148,156 childless adults enrolled in Wisconsin Medicaid representing 12.53 percent of the Medicaid population.

The expansion of coverage to include residential treatment for substance use disorder coverage will apply to all members in the BadgerCare Plus and Medicaid programs in need of such services, not just the childless adult group.

4. **What are the policy changes included in the BadgerCare Reform demonstration waiver?**

The policy changes approved in the waiver amendment include:

- **Establishing monthly premiums.** Instituting small premiums of \$8 per household (or less depending on income and healthy behaviors) will align BadgerCare Plus more closely with private insurance policies.
- **Requiring members to complete a health and wellness questionnaire.** Similar to many commercial insurance plans, to be eligible for benefits, members will be required to submit a health risk assessment which provides information on their health and wellness, including any drug use.
- **Improving access to treatment for substance use disorder.** The new policy allows for full coverage of residential treatment for substance use disorder. Expanding treatment for those battling substance abuse is an important part of Wisconsin's efforts to combat a statewide drug abuse epidemic. This improved access is available not only to childless adults, but all Medicaid and BadgerCare Plus members.
- **Rewarding healthy behaviors.** Members can reduce the premium they may have to pay by making healthy lifestyle choices. Wisconsin Medicaid will reward healthy behaviors, such as wearing a seatbelt, maintaining a healthy weight, not smoking, and not abusing or misusing drugs or alcohol, by reducing premiums.
- **Establishing emergency department copayments (for non-emergency use).** If a member uses an emergency department for care in a non-emergency situation, they may be asked to pay a copayment of \$8. Appropriate utilization of health care services, including emergency department and primary care physician services, can improve the long-term health of our members and our health care system.
- **Limiting eligibility for benefits to 48 months for those in noncompliance.** For those childless adults between the ages of 19 and 49 who do not meet an exemption, eligibility for benefits is limited to 48 months. If a member is working or participating in a worker training program or other community engagement at least 80 hours a month, that month is not counted toward the 48-month limit. Once a member accumulates 48 months during which they have not met these work or community engagement requirements or if they do not meet an exemption, they will lose eligibility for six months. After six months, they may reapply for benefits and the 48-month limit of benefits resets.

5. **Why is Wisconsin Medicaid making these changes?**

As part of Governor Walker's "Wisconsin Works for Everyone" initiative, this new set of policies will help more people move from government dependence to true independence by encouraging work and providing incentives for healthy lifestyles.

Wisconsin has a strong economy with historically low levels of unemployment, and nearly 100,000 jobs available on the state [Job Center](#) website. Community engagement that focuses on work skills can help move people out of poverty and into the workforce, helping build our economy and better futures for our members. Research on the social determinants of health show us that people who are working are healthier than those who are not.

6. **When will Wisconsin Medicaid make these changes?**

Wisconsin Medicaid will work for at least one year from October 31, 2018, to put these new policies in place. DHS will work with members, providers, partners, and other stakeholders across the state to get valuable input, suggestions, and feedback to help us build our implementation plan.

Members will receive notice of any changes that may affect them before Wisconsin Medicaid makes any changes.

7. What if a member is a childless adult, but becomes pregnant?

Pregnant women are not subject to childless adult program requirements. If a member becomes pregnant, she may be eligible for health care coverage under BadgerCare Plus as long as she meets eligibility requirements

8. Does a member who is physically or mentally unable to work still need to meet the community engagement requirement?

If a member is physically or mentally unable to meet the community engagement requirement, he or she may be exempt. A member's doctor will be able to provide Wisconsin Medicaid the necessary documentation to exempt him or her from this requirement.

9. How do these changes affect other health care benefits?

BadgerCare Plus members will receive the same full coverage benefits. If needed, members will receive the added coverage for residential treatment for substance use disorder.

10. How will DHS measure success under this demonstration?

DHS will contract with an independent party to evaluate the implementation and effectiveness of the demonstration waiver. The evaluator will be tasked with ensuring that necessary data is collected and assessed to measure the success of the policy changes outlined above. This information will be reported to the federal government.

11. Will this affect work Wisconsin has done to eliminate the coverage gap?

Because of Governor Walker's BadgerCare Reform, for the first time ever, everyone living in poverty in Wisconsin has access to health care services. The approval of our extension means that in Wisconsin, all residents will continue to have access to health care coverage through either employer-sponsored or private insurance, a public assistance program, or the health insurance marketplace. This innovative approach to reform allows access to care for tens of thousands of individuals living below the federal poverty level.

B. Health Risk Assessment and Drug Screen

1. What is a health risk assessment?

A health risk assessment is a screening tool that asks questions to determine health risks and/or health needs. This assessment helps doctors and care coordinators improve management of medical conditions. For example, if someone reports during their assessment that they would like to quit smoking, their doctor or care coordinator will connect them with resources to help them achieve their goal.

The health risk assessment will include items such as use of seatbelts and use or misuse of products, including tobacco, alcohol, and controlled substances.

2. When will applicants and members complete the health risk assessment?

Applicants and members will be required to complete the health risk assessment when applying for benefits and during their annual benefits renewal.

3. What ways may someone complete the health risk assessment?

Applicants and members will be able to complete the health risk assessment online via ACCESS, over the phone, on paper, or in person.

4. What if the health risk assessment is not completed?

Completion of the health risk assessment is required to be eligible for benefits. If an applicant or member does not complete the health risk assessment when applying for or renewing benefits, he or she will not be eligible for Medicaid benefits.

5. Why is Wisconsin Medicaid requiring answers to these questions?

Health screening tools are used in the private insurance market to help people break free from unhealthy activities that can lead to increased health care costs and to incentivize behaviors that lead to longer, healthier lives. By helping our members lead healthier lives, we can also save health care dollars.

6. What are health risk behaviors?

Health risk behaviors are activities a person may engage in that has a strong influence on health outcomes. Some examples of these behaviors include diet, exercise, tobacco, drug or alcohol use, and behaviors related to safety, such as wearing seatbelts.

7. What are the questions related to drug use that are part of the health risk assessment?

The drug use questions will ask about any use of controlled substances (for example, medications, illicit drugs, etc.). Wisconsin Medicaid will use the Drug Abuse Screening Test (DAST-10) for the drug screen.

8. What will happen if a member screens positively for substance use disorder?

The member will be referred to be assessed for treatment. Eligibility for health care benefits is not impacted by the results of the screen.

9. Will members have to take a drug test?

Under the terms of the approved waiver, members will not be required to take a drug test to be eligible for benefits. However, a health care provider may recommend drug testing as part of a member's treatment plan.

10. Who will pay for the substance use disorder treatment?

Wisconsin Medicaid will pay for treatment.

11. What will happen if a member refuses treatment?

At this time, entering or completing treatment is not a condition of receiving health care benefits.

C. Premium Payments and Rewarding Health Behaviors

1. Who has to pay premiums?

Non-pregnant, childless adults ages 19 through 64 with income above 50 percent of the federal poverty level and up to 100 percent of the federal poverty level will have a premium requirement.

To find out where household income falls, see the [DHS BadgerCare Plus Federal Poverty Levels website](#) for more information.

2. How much are premiums?

Premium amounts are based on monthly household income and healthy behaviors. If monthly household income is above 50 percent of the federal poverty level and up to 100 percent of the federal poverty level, the premium is \$8 per month per household. If monthly household income is 50 percent or less of the federal poverty level, there is no premium.

Monthly Household Income	Monthly Premium Amount
0% to 50% of the federal poverty level	No premium
51% to 100% of the federal poverty level	\$8 per household

Members who report healthy behaviors during their health risk assessment such as wearing a seatbelt, maintaining a healthy weight, not smoking, not abusing or misusing drugs or alcohol, will see their monthly premium payment cut in half, reducing it to \$4.

In a two-person household where only one of the members is participating in healthy behaviors, the premium will be prorated at \$6 for the household.

3. What if a member is already trying quit or cut down on an unhealthy behavior?

Members already working toward quitting smoking, cutting back on alcohol, or otherwise managing behaviors that put their health at risk, may also be eligible for the 50 percent monthly premium reduction. This effort may be reported on the health risk assessment.

4. What if a member has a health issue that negatively affects their health risk assessment?

If a member has a health condition that is beyond their control, he or she may still be eligible for the 50 percent monthly premium reduction. Such conditions may be self-reported on the health risk assessment. For example, a member taking a medication that causes weight gain will have the opportunity to self-report this when completing the health risk assessment.

5. Can others help make premium payments?

Yes, third-party contributions are allowed to help members make premium payments. Third-party contributors may include, but are not limited to, nonprofit organizations, churches, provider groups, or family members.

6. What if household income changes?

Any income changes, or other changes that must be reported, must be reported by the 10th day of the month following the change and during annual renewal. Premium payments will be recalculated and may change when reported income changes.

For example, if income increases from 45 percent to 75 percent of the federal poverty level in April, a member will have until May 10 to report changes to their local agency.

7. Will health plans or HMOs be collecting premiums?

No, premiums will not be collected by health plans or HMOs. Wisconsin Medicaid will work with all stakeholders to develop the process by which premium payments will be collected.

9. When are premium payments due?

Premiums will be due monthly.

10. What happens if a member does not make a premium payment?

Unpaid premiums not made by the time of annual renewal will mean an ineligibility period of six months. However, a member may reenroll at any time during the six-month lockout by paying late payment(s).

11. Are there exemptions from paying the monthly premium?

Members with income under 50 percent of the federal poverty level, or income changes to be under 50 percent of the federal poverty level, will be exempt from paying premiums.

12. Can premiums be pre-paid?

Wisconsin Medicaid will develop the process for collecting premium payments as part of the implementation plan with stakeholders over the coming year and will update this information as it becomes available.

D. Emergency Department Copayment

1. What will the copayment be for emergency department services?

Members will be charged a copayment of \$8 per visit if they visit the emergency department for care in a non-emergent situation. The \$8 copayment will be waived if the visit is determined by the provider to be emergent.

2. How does Wisconsin Medicaid determine if the visit is emergent?

Copayments will be waived if the member is found to have an emergency condition, or if the person is admitted to the hospital within 24 hours of the original visit. All emergency department visits where a copayment may be applied are subject to a “prudent layperson review” to determine whether an emergency medical condition existed for the purposes of applying the copayment.

3. What is the definition of a “prudent layperson review” of whether a visit is emergent?

The “prudent layperson review” as defined in section 1867 (e) (1) (A) of the Emergency Medical Treatment and Active Labor Act is as follows:

“Any medical or behavioral condition of recent onset and severity including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in serious dysfunction of any bodily organ or part, or in the case of a behavioral condition placing the health of such person or others in service jeopardy.”

4. What if a member cannot pay their emergency department copayment?

Federal law requires hospital emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay. Additionally, Medicaid providers may not deny services to Medicaid members who are unable to pay a copayment. However, providers are permitted to attempt to collect copayments owed to them after the service has been provided.

5. Is there a limit to what can be charged for the premium and emergency department copayments?

Yes, federal regulations limit charges for Medicaid health care benefits to 5 percent of household income.

E. Residential Treatment Coverage

1. Has the coverage policy changed for residential treatment? Was it not covered before?

Recognizing the critical role of residential substance abuse disorder treatment in combatting the opioid crisis, Wisconsin Medicaid will be allowed to fully cover residential (inpatient) treatment for substance use disorder through this waiver provision. Previously, federal policy restricted coverage of residential substance abuse treatment, which created a significant barrier for members in need of this level of treatment to access appropriate levels of care.

This benefit provides parity with commercial insurance.

Full coverage of residential treatment will allow members to spend the time they need to fully recover and prepare to live independently. This initiative is part of Governor Walker's comprehensive approach to address the opioid epidemic in the state.

2. If a member needs substance use disorder treatment, what will Wisconsin Medicaid cover?

- Outpatient treatment: Mental health professionals and counselors will assess the level of need and provide counseling services.
- Day treatment: A doctor will develop a program specifically for the member, typically no less than 12 hours per week. The member will receive an assessment, counseling, and a plan to treat their disorder.
- Psychosocial Rehabilitation: This includes wraparound psychosocial rehabilitative services to address substance use disorder to support independent living in the community.
- Medication-assisted treatment (MAT): This includes assessment, drug screening, prescription and administration of opioid dependency agents, and substance abuse counseling.
- Inpatient Treatment: This includes medically necessary acute care in a hospital for members with substance use disorder.

3. Who will pay for the substance abuse treatment?

Wisconsin Medicaid has committed to cover the costs associated with substance abuse treatment to help our members get the treatment they need to live their best lives.

4. What if there is not access to these services in my area?

There is a comprehensive effort in Wisconsin to increase both access to treatment and the number of providers available to provide treatment through the Governor's Opioid Task Force. Newly Medicaid-covered services are one tool we are using to grow our provider network. As part of our yearlong implementation plan, we will be working to expand our network of providers and developing a plan for how we will best connect individuals in need of treatment to providers. We will work collaboratively with stakeholders to expand access to medication-assisted treatment to address the growing demand for treatment.

5. Will members be kicked off the program if they are addicted to drugs?

No.

F. 48 Month Eligibility and Community Engagement

1. How does the 48-month eligibility limit work?

Childless adults between the ages of 19 and 49 will have 48 months of Medicaid eligibility (consecutive or non-consecutive months). After 48 months of eligibility have been used, there will be a six-month waiting period before they may re-enroll as a childless adult. Any months during which an individual is participating in community engagement or meeting an exemption will not count towards the 48-month eligibility limit.

2. What is community engagement?

Community engagement is defined as employment (paid or unpaid), training, or education. Various programs or activities can support the community engagement requirement.

3. Are there exemptions to the 48-month limit?

Yes. The 48-month limit applies only to those individuals ages 19 to 49. Additionally, members who are unable to work for any of the following reasons, will be exempt from community engagement.

- a. A member is unable to work or participate in the workforce training activities, which includes any of the following situations:
 - i. Receiving temporary or permanent disability benefits from the government or a private source (for example., Social Security Disability Insurance)
 - ii. Mentally or physically unable to work, as determined by the state
 - iii. Verified as unable to work in a statement from a health care professional or a social worker
 - iv. Experiencing chronic homelessness
- b. A member is a primary caregiver for a person who cannot care for himself or herself.
- c. A member is receiving or has applied for unemployment compensation and is complying with the work requirements.
- d. A member is exempt from Supplemental Nutrition Assistance Program work requirements.
- e. A member is regularly participating in an alcohol or other drug abuse treatment or rehabilitation program not including Alcoholics Anonymous or Narcotics Anonymous. (Including verified participation in cultural interventions specific to the Native American community and other similar programs.)
- f. A member is enrolled in an institution of higher learning (including vocational programs or GED classes) at least half-time.
- g. A member is attending high school at least half-time.

Those who meet an exemption from the community engagement requirement may be asked to provide proof of the exemption. The months that the exemption applies will not count towards the 48-month limit.

4. If diagnosed with a serious health condition (for example, cancer, end stage renal disease, cystic fibrosis, or HIV), is a member exempt from the 48-month limit?

Specific conditions are not automatically exempted; however, if a health care professional provides verification that a member is physically unable to work due to a condition, they would meet an exemption for months they are unable to work.

5. What if a member has good cause for not participating in community engagement for a brief period?

A member, who is not otherwise exempt from the 48-month time limit, may be exempt from the requirement for a period in which they have a good cause reason for not meeting the community engagement requirement. Good cause applies to circumstances that are typically beyond a members' control that prohibit he or she from meeting the community engagement requirement. Good cause may include things like illness, an illness of a family member that requires a member to miss work or other scheduled community engagement activities, a vehicle breakdown, or other circumstances.

6. What happens when a member reaches 48 months of enrollment?

If a member reaches the 48-month limit, they will lose program benefits for six months. After six months, he or she is eligible to re-enroll in the program if he or she meets all other program rules, at which time another 48-month time limit count will begin.

7. When does the 48-month count begin?

For the program as a whole, the 48-month count will begin no sooner than 12 months after approval of the waiver. For individual members, the start of the time limit will be determined as the implementation plan is fully developed. Members will receive notification prior to any changes in their health care program requirements.

8. What activities count towards the community engagement requirement?

Members will be considered active in community engagement through a variety of activities, including but not limited to:

1. Working in exchange for money.
2. Working in exchange for goods or services (in-kind).
3. Unpaid work (for example, volunteer work, community service).
4. Self-employment at any wage.
5. Taking part in an allowable employment and training program, such as:
 - a. FoodShare Employment and Training (FSET), including FSET Workfare component (the state's supplemental nutrition assistance program).
 - b. Wisconsin Works (W-2).
 - c. Workforce Innovation and Opportunity Act programs.
 - d. Refugee Employment and Training.
 - e. Trial Employment Match Program.
 - f. Children First.
 - g. Programs under section 236 of the Trade Act.
 - h. Tribal work programs.
 - i. Other state-approved workforce programs.

A member must complete at least 80 hours per calendar month of any of the above qualifying activities.

9. If a member is meeting the work requirement for another state program, will that count for Medicaid?

Yes. Wisconsin Medicaid will count all work, employment and training activities, and education activities towards meeting the community engagement requirement.

10. Why is Wisconsin Medicaid requiring me to participate in community engagement to get healthcare benefits?

As part of Governor Walker’s “Wisconsin Works for Everyone” initiative, this policy intends to help more people move from government dependence to true independence by assisting members to get job training, encouraging work, and providing incentives for healthy lifestyles.

Research on the social determinants of health shows us that people who are working are healthier. We have a strong economy with historically low levels of unemployment and nearly 100,000 jobs available on the state [Job Center website](#). Community engagement that focuses on work skills can help move people out of poverty and into the workforce, building our economy and building better futures for our members.

11. Who will verify if members are working or participating in community engagement?

Members will provide documentation to their local agency. If a member is participating in the DHS-supported employment and training program, documentation will be provided.

12. Will individuals be required to visit [JobCenterofWisconsin.com](#) or upload a resume there to be eligible for Medicaid?

No.

13. Who will pay for job training services?

Wisconsin Medicaid will pay for job training services. Wisconsin has been a leader in providing job training to help individuals move from government dependence to independence. Many Medicaid members also participate in the Wisconsin FoodShare Employment and Training program.

This program, provided free to FoodShare recipients, works to help assess each member’s individual strengths, needs and helps them find a job. The FoodShare Employment and Training program has helped nearly 30,000 FoodShare recipients gain employment in a few short years. The majority of those enrolled in the program are voluntarily participating.

14. How will Wisconsin Medicaid support people who are looking for work?

Wisconsin Medicaid will provide a free program that helps childless adults build their job skills and find jobs. This program will assess members’ strengths, needs, and preferences to help them get a job.

15. How does a member join an employment and training program?

Members interested in Wisconsin Medicaid-supported employment and training services should contact their [local agency](#) to find out what services are available in their area.

16. What if a member does not have transportation to get to a job or training program?

Members who need help with child care, transportation, or other support services in order to take part in the employment and training program may be able to receive assistance with those needs. To learn more, members will be able to speak to their local agency or employment and training worker.

17. How will members know what employment and training programs are available in their area?

Wisconsin Medicaid will provide information about all of the available programs. Please check back to the DHS Section 1115 BadgerCare Reform demonstration waiver website to find updates to FAQs and other information as it is available.

18. What are the benefits of participating in the Wisconsin Medicaid employment and training program?

The program is free to childless adults and helps individuals gain skills and training necessary to start or change a career. Participants in this program can benefit from the following services, supports, and more:

- Job searches and job referrals
- Job skills assessment
- Career planning
- Job training and education
- Work experience
- Transportation, child care, and other work-related costs
- Referrals to other community services